HOME HEALTH CARE REFERRAL ORDER FORM

Patient Name: _____ DOB: _____

Medicare Number (required): _____ Referral Date: _____

Physician Name: _____ Phone Number: _____

Patient emergency contact: _____ Phone Number: _____

Primary Diagnosis: _____

Skilled Nursing, Physical Therapy, and Speech Language Pathology are qualifying skills (must select at least one)

☐ **SKILLED NURSING EVALUATION**

- ☐ Medication Assessment and Education
- ☐ Wound Care (Explain): _____
- ☐ New Ostomy/Colostomy
- ☐ Observation, Assessment of new or exacerbation of chronic disease
- ☐ Teaching, Training of new or exacerbation of chronic disease
- ☐ Other: _____

☐ **PHYSICAL THERAPY EVALUATION**

- ☐ Recent falls with change in functional activity and reduced participation
- ☐ Change in health condition with weakness/decreased aerobic capacity
- ☐ Joint Replacement
- ☐ Change in health condition with need for DME education
- ☐ Change in health condition with need for home safety education

☐ **SPEECH LANGUAGE PATHOLOGY EVALUATION**

- ☐ Change in health condition with decline in communication or new communication disorder
- ☐ Change in health condition with decline in functional swallowing

☐ **OCCUPATIONAL THERAPY EVALUATION**

- ☐ Recent fall with change in ability to complete ADLs/IADLs
- ☐ Change in health condition with inability to complete ADLs/IADLs
- ☐ Change in health condition with need for DME education
- ☐ Joint Replacement

F2F Encounter Date: _____ **OR** **Date Scheduled:** _____

Influenza Vaccination Received for the current season:	☐ Yes	☐ No	☐ Medically Contraindicated
Pneumococcal Vaccination Ever Received:	☐ Yes	☐ No	☐ Medically Contraindicated
Herpes Zoster Vaccination Ever Received:	☐ Yes	☐ No	☐ Medically Contraindicated

Signature: _____ **Date:** _____
(MD/MD Agent signature and date to indicate order to open Home Health Care and proceed)

Please fax this form to: _____ **and include the following:**

1. **Clinical encounter note and H&P or Discharge Summary**
2. **Current Patient Demographics and Medication List**

For questions, please call BAYADA Home Health Care at: _____